

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 August 2002

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In the Matter of:

**FAYE E. FALIN, on behalf of and as surviving
spouse of, LESLIE FALIN, deceased,
Claimant,**

v.

**WESTMORELAND COAL CO.,
Employer,¹**

and

**DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.**
.....

Case No: 2001-BLA-0785

DECISION AND ORDER DENYING BENEFITS

These proceedings arise out of claims for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (hereafter “the Act”²). The pertinent implementing regulations appear at Parts 718, 727, and 725 of Title 20 of the Code of Federal Regulations.

Technically, although only one case number has been assigned, the above-captioned claim for benefits encompasses two claims, one brought by Mr. Leslie Falin (hereafter “Miner”) and one brought by Ms. Faye E. Falin (hereafter “Claimant”). (*See* DX 56).³ As will be explained, the

¹ As will be discussed *infra*, Westmoreland Coal Co. is technically only a party in the survivor’s claim, not the living miner’s claim, the only claim currently pending before the undersigned.

² The Act was adopted as Title IV of the Federal Coal Mine Health and Safety Act of 1969, and was amended by the Black Lung Benefits Act of 1972, the Black Lung Benefits Reform Act of 1977, the Black Lung Benefits Revenue Act of 1977, the Black Lung Benefits Revenue Act of 1981, and the Black Lung Benefits Amendments of 1981.

³ References to the Director’s Exhibits 1 through 25 and 27 through 56, admitted into evidence at the November 30, 2001 hearing before the undersigned at Abingdon, Virginia, appear as “DX” followed by

only issues currently pending before the undersigned are related to the claim originally brought by Miner. The entire procedural history, however, will be discussed in full detail.

STATEMENT OF THE CASE

Miner filed his first claim for benefits under the Act with the Social Security Administration on June 29, 1973, identifying Westmoreland Coal Co. (hereafter “Employer”) as his last employer in the coal industry in connection with this claim.⁴ (DX 29-21). This claim was denied by Social Security Administrative Law Judge (hereafter “ALJ” or “Judge”) John R. Hood by Decision dated December 5, 1975 after Judge Hood determined that Miner failed to prove that he suffered from “complicated pneumoconiosis,” or that he was totally disabled and unable to engage in mine work (or other comparable employment). (*Id.*).

Less than one year elapsed before Miner filed another claim for benefits, this time with the Department of Labor, on March 1, 1976, in which he identified Employer as his last employer in the coal mine industry and indicated he was still so employed. (DX 29-1, 29-2). A claims examiner from the Department of Labor (hereafter “DOL” or “Department”) notified Miner by letter dated June 25, 1980 that his claim was denied, as the medical evidence submitted failed to establish both that he suffered from pneumoconiosis and that he was totally disabled. (DX 29-17). Additional evidence was submitted. (DX 29-3, 29-12, 29-15). While the record does not show that Miner appealed this decision to the Department’s Office of Administrative Law Judges (hereafter “OALJ”), the record contains a copy of a letter dated November 17, 1982 notifying Miner that

The additional information and evidence submitted following our initial finding dated June 25, 1980 has been carefully considered. Our initial finding that you cannot be found entitled to benefits for the reason(s) previously given remain unchanged by the additional evidence and information.

(DX 29-18). The letter also instructed Miner of his rights, explaining that if he disagreed with this decision, he had sixty days in which he could request a formal hearing before an ALJ, or one year from the initial finding to ask for reconsideration, by submitting supporting evidence, “but only if your condition has changed or a mistake was made when your claim was denied.” (*Id.*). Instead of filing a request for a hearing, Miner next filed a medical report from Dr. Joseph F. Smiddy under cover letter dated December 17, 1982, requesting that it “be made a matter of record in this

the exhibit number and, if necessary, the page number. References to the hearing transcript appear as “Tr.” followed by the page number. DX 26 was specifically not admitted, as that document contained two x-ray interpretation relating to Mr. Kenneth Atkins. (Tr. at 22-23).

⁴ At the time Miner filed this claim, he was still working for Employer, as indicated on his initial claim form and a fact mentioned by Judge Hood in his decision. (DX 29-1, 29-21).

reconsideration.” (DX 29-19). By letter of November 14, 1983, Claimant’s counsel requested the scheduling of a conference. (DX 29-20).

The next correspondence from the Department occurred on May 23, 1984, and informs Miner that the claim he filed on March 1, 1976 is being forwarded to the OALJ for a formal hearing. (DX 29-22; DX 29-37). The claim was forwarded that same date with the “Director OWCP [Office of Workers’ Compensation Programs]” (hereafter “Director”) listed as the respondent. (DX 29-22). After conducting a full hearing on July 9, 1986, Judge Frederick D. Neusner issued a “Decision and Order- Rejection of Claim,” dated September 11, 1987, in which he determined that Miner could take advantage of the “interim presumption,” but that the Director successfully rebutted this presumption by showing that Miner was not “totally impaired by a pulmonary or respiratory disability from the performance of his usual coal mine employment, as provided in 20 C.F.R. § 727.203 (b)(2).” (DX 29-35, 29-37). Judge Neusner next evaluated Miner’s claim under Part 410 of the Regulations, determining that Miner did suffer from pneumoconiosis, but that the disease was not the “primary reason” for his disability. (DX 29-37). As a result of these findings, Judge Neusner denied Miner’s claim.

Miner appealed this decision to the Benefits Review Board (hereafter “BRB”), which affirmed in part, vacated in part, and remanded the action for further consideration by unpublished Decision and Order dated March 31, 1989. (DX 29-38). Specifically, the BRB remanded the case with the instruction that all medical evidence should be weighed together in accordance with *Mullins Coal Co., Inc. of Va. v. Director, OWCP*, 483 U.S. 135 (1987), when determining if Miner suffers from pneumoconiosis for the purpose of evaluating the claim under the interim presumption. (*Id.*). The BRB also acknowledged that the evidence presented was insufficient to rebut the interim presumption, noting that both Miner and the Director agreed on this fact, and remanded the action with instructions to re-evaluate the issue of rebuttal. (*Id.*).

On remand, in a decision of October 11, 1989, Judge Neusner determined that Miner failed to meet his burdens of proof and denied the claim. (DX 29-41). Judge Neusner evaluated all of the x-ray interpretations and medical opinions, determining that the evidence of record was insufficient to invoke the interim presumption under 20 C.F.R. § 725.203(a). (*Id.*). Judge Neusner then analyzed Miner’s claim under Part 410 and arrived at the same conclusion contained in his first decision, *i.e.* Miner failed to establish that he was “totally disabled solely due to pneumoconiosis.” (*Id.*). Finally, pursuant to the BRB’s instruction, Judge Neusner evaluated Miner’s claim under section 410.490, and determined that the claim failed under this section as well. (*Id.*). Miner appealed this decision to the BRB, which dismissed the appeal as abandoned by Order dated December 12, 1990 after Miner failed to file a timely Petition for Review and accompanying brief. (DX 29-42, 29-45).

On December 13, 1990, Miner sent a letter to the Department requesting a modification of Judge Neusner’s decision. (DX 29-46). A DOL representative acknowledged receipt of Miner’s request by letter dated December 18, 1990, simultaneously informing Miner that his claims file was “located with the Benefits Review Board” and that his letter was being forwarded to “our

Hearings and Appeals Section, Washington, D.C. for necessary action and final reply.” (DX 29-47). At this point, the record contains a significant gap in time regarding activity on Miner’s claim, with October 12, 1993 being the next date of correspondence from the Department, which indicates that it is in response to Miner’s request for a status report.⁵ (DX 29-48). Despite the fact that Miner requested a modification of Judge Neusner’s decision nearly three years earlier, a request that the DOL acknowledged, the Department incorrectly instructed Miner to file a new application if he wished to resume activity on his claim.⁶ (*Id.*). The record is devoid of further action on the Miner’s claim during his lifetime. (*See also* Tr. at 6-7).

Unfortunately, Miner passed away on July 12, 1997 due to a self-inflicted gunshot wound to the head. (DX 1, 5). Claimant filed her claim for benefits under the Act on January 29, 1999, identifying Employer as the last coal mine employer Miner worked for. (*Id.*). On March 9, 1999, a claims examiner in the DOL notified Claimant that her claim was denied for failure to successfully prove the following: (1) that Miner suffered from pneumoconiosis at the time of his death; (2) that the disease, if found, was caused at least in part due to Miner’s coal mine employment; and (3) that pneumoconiosis caused Miner’s death. (DX 8). The claims examiner, however, issued a revised notice on April 1, 1999, informing Claimant that the evidence still did not support a finding that she is entitled to benefits, but for the sole reason that Claimant failed to prove that pneumoconiosis caused Miner’s death. (DX 9). Claimant disagreed with this outcome and requested a hearing before the OALJ by letter dated April 8, 1999.⁷ (DX 10). Employer was then notified that a claim was filed in which it was identified as the responsible operator, a designation it timely contested. (DX 12, 15, 19). On September 3, 1999, Claimant, again, requested a formal hearing on this matter before an ALJ, and the claim was transferred to this tribunal under cover memorandum dated December 6, 1999, revised on January 20, 2000. (DX 21, 30, 31, 32). Judge Jeffery Tureck was assigned Claimant’s claim and held a hearing on May 11, 2000 in Abingdon, Virginia. (DX 38, 42). At the hearing, no witnesses testified and counsel for Claimant and Employer requested that Judge Tureck evaluate the claim on the evidentiary record alone. (DX 42, at 12).

On June 16, 2000, Judge Tureck issued a Decision and Order Denying Benefits, addressing only Claimant’s survivor claim. (DX 43, at 2). Judge Tureck began by noting that Miner’s claim was “finally denied on October 11, 1989 [and that] disposition of that claim has no

⁵ Counsel for Employer explained at the most recent hearing that this correspondence is a response to an inquiry made by Miner’s attorney at the time requesting information on the status of Miner’s claim. (Tr. at 7).

⁶ Although the modification was filed more than one year after the date of Judge Neusner’s October 11, 1989 decision, it was timely, because Judge Neusner’s decision did not become final until the appeal was dismissed in December 1990. (DX 29-45).

⁷ The claims examiner acknowledged receipt of Claimant’s request by letter of April 20, 1999. (DX 12).

bearing on [Claimant's] claim.” (*Id.* at 2 n.2). Judge Tureck then addressed the merits of the claim, denying it because Miner's death was due to a self-inflicted gun shot wound to the head, and pneumoconiosis played no role in Miner's death. (*Id.* at 2-3). Claimant appealed this decision to the BRB by letter dated July 5, 2000. (DX 46).

In connection with Claimant's appeal, both the Employer and the Director submitted briefs supporting their positions. In particular, the Director argued that Claimant's appeal is premature, noting that Miner's claim has not been finally resolved given that his December 13, 1990 request for modification was never addressed and, technically, still pending. (DX 48). The BRB issued an Order dated September 20, 2000, remanding Claimant's claim to the district director “for consideration of the Director's petition for modification.” (DX 49). As a result, activity resumed on Miner's claim, which was remanded to the district director.⁸

On remand, the district director denied the claim on the basis that the evidence in the record did not establish that Miner is totally disabled, stating that “it is established that [Miner] is able to do his usual coal mine work.” (DX 50). Claimant submitted a notice of appeal on behalf of Miner on Miner's claim by letter dated February 1, 2001, and the claim was transferred to this tribunal under cover memorandum of May 8, 2001.⁹ (DX 54). The undersigned notified all of the above-captioned parties that a hearing on this matter was set for November 30, 2001 in Abingdon, Virginia by Notice of Hearing and Prehearing Order dated August 16, 2001.¹⁰

At the hearing, counsel for all three of the above-captioned parties appeared. While no witnesses testified, all of the discussion on the record addressed the complicated procedural history of this claim. (Tr. 5-31). Counsel for Employer began by explaining that it was actually never named as a responsible operator in connection with Miner's claim and that due to this fact, Employer should not be party to the Miner's claim on modification. (Tr. at 6-9). The undersigned explained that it is unclear what is currently pending, as only one case number was assigned to seemingly two claims. (Tr. at 9-10). Employer stated that its position is that the Miner's claim is the only claim before the undersigned, with the Claimant's survivor claim merely

⁸ As discussed at the hearing and explained below, the only modification request in the record relates to Miner's claim and, thus, the BRB's remand Order can only be referring to that request. (*See* Tr. at 16-17).

⁹ The record contains a second transmittal memorandum as well at DX 55, but this memorandum apparently refers to Claimant's survivor claim and the issues at matter in that action. (*Compare* DX 54 *with* DX 55; *see also* Tr. at 11). However, only the Miner's motion for modification is before me, and this procedural miscue is noted solely for completeness in describing the entire procedural history related to these two claims.

¹⁰ While not a party to Miner's claim, Employer was mistakenly listed as a party on the transmittal memorandum and, thus, included in the case caption. (DX 54). Employer submitted a letter dated August 27, 2001 explaining that it should not be a named party in the Miner's claim, but would attend the hearing in order to protect its interest(s) regarding Claimant's claim, if necessary.

being “carry-along baggage” and “just along for the ride.” (Tr. at 10, 14). Counsel for the Director took the position that both claims were currently pending, pointing to the fact that there are two transmittal memorandums in connection with this claim number. (Tr. at 11; DX 54 (referring to Miner’s claim issues), 55 (referring to Claimant’s survivor claim issues)). However, Employer pointed to the fact that no motion for modification has ever been made regarding Claimant’s survivor claim and the BRB’s Order does not support the Director’s argument, a point that the Director seemingly agreed with. (Tr. at 11, 14-15; *see also* Tr. at 16-17). Eventually, all parties agreed that Claimant’s survivor claim had not been remanded as part of the BRB’s Order. (*See* Tr. at 17-21). Further, all parties stipulated to the fact that Employer should not be made a party in the Miner’s claim. (Tr. at 20-21). After further discussion, the undersigned determined that the only issues to be addressed in this claim would be related to Miner’s modification request and the case would proceed with this understanding, a determination that satisfied all parties involved. (Tr. at 21).

Upon completion of the hearing, the record was not held open for any purpose. (Tr. at 26). However, Claimant was granted a thirty day period to submit a post-hearing brief, followed by another thirty day period to allow Director to submit a reply brief if necessary. (Tr. at 26). Only Claimant elected to file a post-hearing argument, which is dated December 27, 2001 and was filed on January 2, 2002. The record is now closed and the Miner’s claim is ready for decision.

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted. Where pertinent, I have made credibility determinations concerning the evidence.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

The following matters are at issue (DX 54):

1. Whether Miner had pneumoconiosis;
2. Whether the pneumoconiosis arose out of coal mine employment;
3. Whether Miner was totally disabled;
4. Whether Miner’s disability was due to pneumoconiosis; and
5. Whether the evidence establishes a change in conditions and/or that a mistake was made in the determination of any fact in the prior denial per 20 C.F.R. § 725.310.

(DX 54). As discussed above, the record contains a second transmittal memorandum (DX 55), but as those issues concern Claimant’s survivor’s claim, they will not be addressed in this Decision

and Order. (Tr. at 11, 21). Further, all parties stipulated that Employer is an improperly named party regarding the Miner's claim and should not be a party to this claim. (Tr. at 20-21). Regarding DX 54, although length of coal mine employment is listed on the CM-1025 Form, counsel for Director withdrew this issue after Claimant and Director stipulated to a length of coal mine employment of thirty-two years, the length found by Judge Neusner in his previous decision. (Tr. at 24). Finally, "Refiled Claims" is incorrectly listed as an issue, as Miner's motion for modification was filed well within one year after Judge Neusner's decision become final. As such, this issue will not be addressed.

Background and Employment History

On his claim form, Miner reported that his date of birth was October 24, 1924, that the highest level of education he completed was the eighth grade, and that he previously filed for black lung benefits but was denied, as discussed above. (DX 29-1). Miner further reported that he married his wife, Claimant, in June 1963 and, together, they had two minor children.¹¹ (DX 29-1; *see also* DX 4 (Marriage Certificate)). At the hearing before Judge Neusner, Miner testified that he was currently living with Claimant at the time of trial, and the record reflects the fact that Miner and Claimant remained married until Miner's death in 1997. (*See* DX 29-35, at 10; DX 5).

At the time Miner filed this claim, he listed Employer as his current employer. (DX 29-1). Later, he reported that he ceased working for Employer in January 1981 after approximately thirty-six to thirty-seven years of employment with Employer, an employment history that is supported by the record.¹² (DX 18; 29-5; 29-35, at 10, 12, 14). Testimony and employment records show that Miner worked primarily as a repairman, a mechanic, and an electrician while with Employer, and that he worked a large part of his career at the face of the mine, averaging "about fifty to sixty hours [of work] per week." (DX 29-1; 29-4; 29-35, at 10-11, 17). Miner's most recent Social Security Employment Earnings Records support Judge Neusner's determination and the parties' stipulation that Miner worked in the coal mine industry for thirty-two years. (DX 18).

At the previous hearing, in July 1986, Miner testified that he stopped working because he was reassigned and required to work at the tippie, but he was unable to physically carry his tools, which weighed between twenty and thirty pounds, back and forth to his new work site. (DX 3; 29-35, at 12). After leaving Employer, Miner stated that he had not engaged in any other work

¹¹ Miner also reported a previous marriage, lasting from January 1948 to January 1963, and that this marriage ended in divorce. (DX 29-1). Also, Miner testified that he has seven children in all. (DX 29-35, at 12).

¹² In fact, Employer's own records state that Miner retired on January 31, 1982, which is confirmed by the Social Security Employment Records. (DX 18, 20).

and, thus, Employer was his last coal mine employer.¹³ (*See id.* *But see* DX 18 (reporting income earned from “self-employment” from 1981 to 1986) and DX 29-19 (Dr. Smiddy’s 1984 medical report stating that Miner was working in the restaurant at the time he was examined)). Miner further testified previously that he had much difficulty contributing to daily household chores, such as grocery shopping and mowing the lawn. (DX 29-35, at 13). In addition, he testified that he had been seeing Dr. Smiddy for the past five or six years for his breathing and for insulin-dependent diabetes. (DX 29-35 at 14). Finally, the record indicates that Miner did not ever smoke tobacco or drink alcohol at any point in his life. (*See, e.g.*, DX 28, 29-10, 29-19, 29-23, 29-32, 29-46).

Medical Evidence

The following medical evidence is all of the evidence of record.¹⁴

X-ray Interpretations. The table below summarizes the x-ray evidence submitted in connection with this claim.¹⁵

Exhibit Number	Date of X-ray	Physician	Qualifications¹⁶	Interpretation
DX 29-21	7/17/72	Dr. James M. Profitt	Unknown	Film quality 3. Completely negative.

¹³ On cross-examination, Miner did testify that he occasionally helped Claimant operate a family-owned restaurant, but his assistance was limited to “occasionally” doing some “book work,” and he never performed any manual labor. (DX 29-35, at 14). According to Miner’s testimony, Claimant has always run the restaurant without his help. (*See id.* at 17).

¹⁴ The record contains several pages of treatment notes taken by various physicians. These notes generally relate to Miner’s other ailments (*e.g.*, colon cancer and diabetes), although they reflect Dr. Kanwal’s treatment of Miner for COPD [Chronic Obstructive Pulmonary Disease] in 1984 and 1985, and they have been considered to the extent they are legible and relevant. (*See* DX 16, 29-11, 29-34, 29-39).

¹⁵ “CWP” means Coal Workers’ Pneumoconiosis; and “BCR” means Board-certified Radiologist.

¹⁶ When not clear from the record, I have consulted the website of the American Board of Medical Specialties (www.abms.org) for information on board certifications, and the OALJ’s web site (www.oalj.dol.gov) for information on NIOSH-approved B-readers, for both of which I take official (administrative/judicial) notice.

DX 29-11	6/12/73	Dr. Shiv Navani	BCR, A-Reader ¹⁷	CWP of the type p 1/1. Linear atelectatic area in right lower zone. No focal pulmonary disease, but “small densities scattered in the lungs indicat[e] mild [CWP].”
DX 29-21	6/12/73	Dr. J. M. Straughan	A-Reader	“Fibrosis on the basis of pneumoconiosis, simple, Category 1/1 P.” “[S]mall rounded densities extending beyond the hilar margins.”
DX 29-11	2/6/75	Dr. Navani	BCR, B-Reader	CWP of the type p 1/0. Notes that x-ray is consistent with the 6/12/73 x-ray, although the small scattered densities in the “lung parenchyma are consistent with changes of [CWP].” “No acute cardiopulmonary disease process is seen.”
DX 29-14	9/21/77	Dr. Navani	BCR, B-Reader	Films are “in relatively poor inspiration.” “No radiographic evidence of changes of [CWP] is demonstrable - 0/0.”
DX 16, 29-15	6/3/80	Dr. R. Ramakrishnan	BCR, A-Reader	Diagnosis of pneumoconiosis of category p, 1/0, suggested by punctiform densities in the lungs. No acute or focal pulmonary abnormalities. Aorta shows arteriosclerotic changes.
DX 29-15	6/3/80	Dr. E. N. Sargent	BCR, B-Reader	Completely negative
DX 29-19	9/15/82	Dr. Larry H. Westerfield	A-Reader	Small rounded opacities of type q/p, with 1/1 profusion size in all six zones, but no pleural abnormalities consistent with pneumoconiosis. Old parenchymal scar in the right middle lobe.
DX 17	6/29/84	Dr. M. Ranavaya	B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl].
DX 29-32	12/5/84	Dr. Richard Mullens	None	“Minimal diffuse nodular interstitial lung disease unchanged from July 1973.” “Diffuse small discrete 1 to 2 mm. nodular densities throughout both lungs as described in 1973,” with “no apparent progression of interstitial lung disease.”
DX 29-33	12/5/84	Dr. Navani	BCR, B-Reader	Film quality 3. Pneumoconiosis, p/p, 1/0, five zones.

¹⁷ Dr. Navani’s *curriculum vitae* is included in the record at DX 29-33. Originally an A-reader, Dr. Navani later qualified as a B-reader.

DX 29-26	5/8/86	Dr. Navani	BCR, A-Reader	No evidence of pneumoconiosis; 0/0.
DX 29-28	5/8/86	Dr. S. K. Paranthaman	B-Reader	No evidence of pneumoconiosis; 0/0.
DX 29-31	5/8/86 ¹⁸	Dr. Jon Pitman	BCR, B-Reader	Completely negative
DX 17	9/29/87	Dr. Ranavaya	B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl].
DX 17	10/3/88	Dr. Ranavaya	B-Reader	Film quality 3. No abnormalities consistent with pneumoconiosis. Pleural thickening [pl].
DX 17	1/3/90	Dr. Ranavaya	B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl].
DX 24	5/2/94	Dr. Paul S. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis, or evidence of silicosis or CWP. Pleural thickening [pl], as well as focal arteriosclerosis aortic arch.
DX 24	5/2/94	Dr. William W. Scott, Jr.	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Few small calcified granulomata right lung and hilum."
DX 24	5/3/94	Dr. Wheeler	BCR, B-Reader	Film quality 3. No abnormalities consistent with pneumoconiosis. Some pleural thickening [pl], as well as focal arteriosclerosis aortic arch. "Minimal interlobar effusion or fibrosis minor fissure."
DX 24	5/3/94	Dr. Scott	BCR, B-Reader	Film quality 3. No abnormalities consistent with pneumoconiosis. "Few small calcified granulomata right hilum and lung." "Thickened minor fissure, probably small pleural effusion." Pleural thickening [pl].
DX 24	7/6/94	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis, or evidence of silicosis or CWP. Focal arteriosclerosis aortic arch. "Subtle thickening minor fissure or interlobar effusion." Pleural thickening [pl].

¹⁸ Although the x-ray date is typed as "05/08/86", Dr. Pitman listed the date of reading incorrectly as "6/17/81."

DX 24	7/6/94	Dr. Scott	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Few small calcified granulomata right lung and hilum. Thickened minor fissure." Pleural thickening. [pl].
DX 24	7/7/94	Dr. Wheeler	BCR, B-Reader	Unreadable film
DX 24	7/7/94	Dr. Scott	BCR, B-Reader	Unreadable film
DX 7	7/7/94	Dr. Srikumar Gopalan	BCR, A-Reader	Enlarged cardiac size; pulmonary vasculature mildly congested, possibly due to supine position of Miner; no interstitial or alveolar edema, or acute infiltrates. "This is an under penetrated study. Follow up chest films are recommended "
DX 24	4/19/96	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl], as well as focal arteriosclerosis aortic arch. "Subtle interlobar effusion or fibrosis minor fissure."
DX 24	4/19/96	Dr. Scott	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Few small calcified granulomata right hilum. Thickened minor fissure." Pleural thickening [pl].
DX 17	9/9/96	Dr. Ranavaya	B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl].
DX 24	9/9/96	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl]., as well as focal arteriosclerosis aortic arch. "Subtle interlobar effusion or fibrosis minor fissure."
DX 24	9/9/96	Dr. Scott	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Thickened minor fissure. Few small calcified granulomata right lower lung."
DX 27	9/9/96	Dr. Young Kim	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Small calcified granulomata - right lower lung. Thickened minor fissure"

DX 16	12/19/96	Dr. S. Saha	Unknown ¹⁹	Mild emphysema noted; heart not enlarged; lungs free of active infiltration; “no acute cardio-pulmonary disease is noted and no change is noted when compared with prior chest radiograph.”
DX 17	12/19/96	Dr. Ranavaya	B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl].
DX 24	12/19/96	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl], as well as focal arteriosclerosis aortic arch. “Subtle interlobar effusion or fibrosis minor fissure.”
DX 24	12/19/96	Dr. Scott	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. “Thickened minor fissure.” Pleural thickening [pl].
DX 27	12/19/96	Dr. Kim	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. “Thickened minor fissure”
DX 24	12/31/96	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis, or evidence of silicosis or CWP. Pleural thickening [pl], as well as focal arteriosclerosis aortic arch. “Subtle interlobar effusion or fibrosis minor fissure.”
DX 24	12/31/96	Dr. Scott	BCR, B-Reader	Film quality 3. No abnormalities consistent with pneumoconiosis. “Few small calcified granulomata right hilum. Thickened minor fissure.” Pleural thickening [pl].
DX 24	2/5/97	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis, or evidence of silicosis or CWP. Pleural thickening [pl], as well as focal arteriosclerosis aortic arch. “Subtle pleural fibrosis in minor fissure compatible with healed inflammatory disease”
DX 24	2/5/97	Dr. Scott	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. “Thickened minor fissure. Few small calcified granulomata right hilum and lung.” Pleural thickening [pl]

¹⁹ The x-ray interpretation is only signed “S. Saha” and a search of the American Board of Medical Specialties’ web site disclosed at least seven different physicians that meet this description. Thus, although he was apparently a hospital radiologist, Dr. S. Saha’s credentials cannot be determined.

DX 7	2/14/97	Dr. Gopalan	BCR, A-Reader	Mildly enlarged cardiac size; no pulmonary edema and lungs free of acute infiltrates; right hemidiaphragm slightly elevated; no pneumothorax or pleural effusion noted.
DX 24	2/14/97	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis, or evidence of silicosis or CWP. "Focal arteriosclerosis and minimal tortuosity aorta."
DX 24	2/14/97	Dr. Scott	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Few small calcified granulomata right lung."
DX 7, 16	5/1/97	Dr. S. Saha	Unknown	"Heart is not enlarged. Lungs show no active infiltration No acute cardio-pulmonary disease is identified."
DX 17	5/1/97	Dr. Ranavaya	B-Reader	No abnormalities consistent with pneumoconiosis. Pleural thickening [pl].
DX 24	5/1/97	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis, or evidence of silicosis or CWP. "Subtle thickening minor fissure or tiny interlobar effusion. Tiny calcified granuloma near right CPA. Focal arteriosclerosis aortic arch" Pleural thickening [pl].
DX 24	5/1/97	Dr. Scott	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Calcified granulomata right hilum and right lower lung. Thickened minor fissure." Pleural thickening [pl].
DX 27	5/1/97	Dr. Kim	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Small calcified granulomata in the right lower lung. Thickened minor fissure"
DX 24	6/12/97	Dr. Wheeler	BCR, B-Reader	No abnormalities consistent with pneumoconiosis, or evidence of silicosis or CWP. Pleural thickening [pl], as well as minimal arteriosclerosis. "Minimal interlobar effusion or fibrosis minor fissure."
DX 24	6/12/97	Dr. Scott	BCR, B-Reader	No abnormalities consistent with pneumoconiosis. "Thickened minor fissure. Small calcified granulomata right hilum." Pleural thickening [pl]

Pulmonary Function Studies. The record contains the results of five pulmonary function studies conducted between July 1976 and May 1986, none of which are qualifying. (DX 29-7,

29-8, 29-19, 29-24, 29-32). However, Dr. Paranthaman noted that Miner's July 22, 1976 "[s]pirometry shows mild to moderate restrictive ventilatory abnormality" (DX 29-7), and a "mild restrictive ventilatory abnormality" in the exam he administered on May 8, 1986. (DX 29-24). Dr. Kanwal noted that Miner's June 3, 1980 test results were compatible with those in an individual suffering from restrictive pulmonary disease. (DX 29-8). Dr. Smiddy made the following observations after viewing Miner's August 15, 1982 test results: "No obstructive defect, mild restrictive defect. Residual volume decreased. Total lung capacity slightly decreased. Diffusion capacity slightly decreased." (DX 29-19). Finally, Dr. Robinette noted "[m]ild restrictive lung disease without significant response to bronchodilator therapy," "flow rates are normal with a decreased FVC," and "[d]iffusion capacity is decreased," after interpreting the December 5, 1984 test he administered. (DX 29-32).

Arterial Blood-Gas Tests. The record contains eight arterial blood-gas test results, none of which are qualifying.²⁰ Except for the most recent ABG, for which the date is partly obscured, all were taken in the 1980's. (DX 16; 29-8; 29-13; 29-19; 29-25; 29-32; 29-34). However, Dr. Kanwal noted that he observed "mild dyspnea" when administering his exam on August 8, 1989, and noted hypoxia on his June 3, 1980 and August 22, 1985 tests. (DX 16, 29-8, 29-34). Dr. Paranthaman noted "moderate resting hypoxemia, mild deterioration on exercise" after interpreting the test he administered on July 2, 1980. (DX 29-13). On a second test he administered on May 8, 1986, Dr. Paranthaman commented that Miner exhibited evidence of "mild to moderate resting hypoxemia," and that his arterial oxygen tension improved during exercise. (DX 29-25). Dr. Robinette also noted mild resting hypoxemia in December 1984. (DX 29-32). The most recent test, taken May 1, 199[?] [probably 1997], showed a pCO₂ of 38.6 and a pO₂ of 80.8. (DX 16).

Autopsy Report. An autopsy report dated August 13, 1997 from Dr. David W. Oxley is also included as part of the record. Dr. Oxley examined Miner's body on July 14, 1997, and made the following pathological diagnoses: (1) gunshot wound to head and brain, which is noted as the cause of death; (2) adenocarcinoma of colon with general metastasis; (3) bilateral pleural effusion and ascities; (4) coronary arteriosclerosis; (5) cholecystectomy and colectomy; and (6) right mid-thigh amputation. Dr. Oxley noted that a review of the heart showed "moderate coronary arteriosclerosis amounting to 20%." When Dr. Oxley examined Miner's lungs, he observed "subpleural anthracotic deposition," but noted that "[t]his does not appear to involve the parenchyma." However, he further noted that "[t]he parenchyma is atelecratic and purplish red." Dr. Oxley stated that Miner's "neck organs" were "[i]ntact with no airway obstruction." Finally, microscopic observations of the lungs revealed "small quantities of anthracotic material primarily perivascular in location," as well as "occasional scattered areas of intraparenchymal and subpleural anthracotic material." The "microscopic diagnosis" was "Coal worker's pneumoconiosis (mild)." (DX 6).

²⁰ Both Drs. Jarboe and Castle believe that some of the studies Drs. Paranthaman and Smiddy administered are invalid for various reasons. (See DX 35, 37).

Medical Opinions. The following medical opinions were submitted in connection with this claim:

1. **Dr. J. C. Buchanan** offered two medical reports dated April 27, 1970 and July 17, 1972. Dr. Buchanan did not note any respiratory or pulmonary abnormalities in Miner, although he did note that Miner was “obviously overweight.” (DX 29-11).
2. **Dr. W. Baynard Barton** offers a diagnosis of “Stage 1 pneumoconiosis” in a medical opinion of September 7, 1973. Dr. Barton noted that a chest x-ray taken the same date as the opinion showed “[a] modest profusion of small opacities of 1 p Category.” Dr. Barton also diagnosed Miner with “[m]oderate diabetic syndrome with hypertensive trend.” He noted that Miner’s chief complaint was shortness of breath, which Miner reported had troubled him for the past year, and also that Miner was “slightly obese.” (DX 29-9).
3. A diagnosis of hypertension, mild obesity, and mild chronic bronchitis, all related to Miner’s coal dust exposure, was made by **Dr. S. K. Paranthaman**, who is Board-certified in the area of internal medicine, in a report dated July 23, 1976. Within the report are the results of an x-ray interpretation, which notes “thickened minor fissure” and “q 1/0” as observations made after reviewing the x-ray (the x-ray itself is not identified). Dr. Paranthaman also noted that Miner suffered from shortness of breath for the past ten years, but no cough, and that Miner was forty pounds overweight. (DX 29-10, 29-30).
4. **Dr. G. S. Kanwal**, who is Miner’s treating physician, diagnosed Miner with chronic bronchitis, hypertension, and diabetes mellitus in a medical report dated July 17, 1980. In the report, Dr. Kanwal noted Miner’s coal dust exposure, as well as an undated x-ray interpretation that showed “arteriosclerotic changes” in Miner’s aorta, as well as “punctiform densities” in his lungs “suggestive of pneumoconiosis of the category p 1/0.” Dr. Kanwal stated that Miner reported a ten year history of shortness of breath, coughing, phlegm, wheezing and chest pain. Finally, Dr. Kanwal noted that Miner was “moderately overweight.” (DX 29-12; *see also* DX 29-46 (November 1990 report stating that he has treated Miner for past ten years)).
5. **Dr. Joseph F. Smiddy**, who is Board-certified in internal medicine and eligible to pursue a subspecialty in pulmonary disease, offered a medical opinion dated September 24, 1982. Dr. Smiddy began by noting Miner’s history of shortness of breath, coughing, and wheezing, and stated that Miner was obese. Dr. Smiddy’s impression was that Miner suffered from CWP, congestive heart failure, and hypertension. Dr. Smiddy based his diagnosis on the above-mentioned medical tests that he personally administered, including a chest x-ray that he stated

confirms the presence of pneumoconiosis. Dr. Smiddy arrived at the conclusion “that [Miner] has sufficient Pneumoconiosis to produce the arterial hypoxemia to the degree we see and the mild pulmonary function abnormalities as reported and that further that [Miner’s] respiratory condition is of a sufficient degree to preclude the type of activity required for Coal Mine Employment.” (DX 29-19).

6. A December 31, 1984 medical opinion from **Dr. Emory Robinette**, who personally examined Miner, was offered, in which Miner is diagnosed with “[s]imple [CWP] with perfusion abnormality of 1/1 with predominantly Q/P opacities,” as well as “exogenous obesity.” Dr. Robinette began by noting Miner’s complaints of dyspnea on exertion and coughing, and noted that “there was discrete small 1 to 2 mm. nodular densities throughout both lung fields as described in 1973 without evidence of progression in [Miner’s] interstitial lung disease.” In addition to diagnosing Miner with simple CWP, Dr. Robinette stated that Miner showed evidence of restrictive lung disease with an impaired diffusion capacity suggesting an interstitial pulmonary process, and mild resting hypoxemia. Dr. Robinette concluded by stating that he “feels that [Miner] has CWP,” and that the disease contributes to his hypoxemia, although his obesity may cause this as well. However, Dr. Robinette did not believe that Miner’s obesity “would account for [his] diminished diffusion capacity observed or for the decrease in his resting arterial blood gases.” He also did not believe that Miner could return to any form of employment which would require significant dust exposure. (DX 29-32, 29-40).
7. A second medical opinion from **Dr. Paranthaman**, dated May 15, 1986, was also submitted. Dr. Paranthaman did not note any outward physical abnormalities, although he did note Miner’s history of coughing, exertional dyspnea, and wheezing. After reviewing the laboratory data available, he concluded that Miner “is not diagnosed to have [CWP],” as his chest x-ray did not reveal any abnormalities consistent with the disease. Dr. Paranthaman did state that Miner’s “symptoms of chronic bronchitis are probably due to coal dust exposure” given that he was a non-smoker. The arterial blood gas test and spirogram revealed a “mild to moderate” degree of functional abnormality through a decreased FVC, and mild hypoxemia, but no significant airway obstruction. In his opinion, Miner retained the capacity to engage in his previous employment, but he felt that all of Miner’s medical problems (and in particular his hypertension and diabetes, if not controlled) “will make it difficult to do the job of a miner on a eight hour basis.” (DX 29-23).
8. **Dr. Kanwal** submitted another medical report dated November 19, 1990, offering a diagnosis of chronic lung disease with chronic bronchitis, as well as heart failure and diabetes mellitus. Dr. Kanwal opined that Miner was totally and permanently

disabled, and that he felt Miner's "respiratory symptoms and condition is related to coal mine exposure." (DX 29-46).

9. **Dr. Echols A. Hansbarger, Jr.**, who is Board-certified in pathology as well as forensic examination and medicine, and possesses subspecialties in the areas of anatomic and clinical pathology, and blood banking, offered a medical opinion dated October 17, 1999. Dr. Hansbarger reviewed "the available medical records" of Miner, as well as five slides containing sections of Miner's lungs. A microscopic examination of the slides revealed to Dr. Hansbarger that Miner suffered from slight centrilobular emphysema of the lung, congestion of the lung, and "pulmonary anthracosilicosis, mild, focal ([CWP]- dust reticulation type)." Dr. Hansbarger determined that "the findings of pulmonary anthracosilicosis of a degree just sufficient to warrant the diagnosis of [CWP] of the dust reticulation type," and offered a diagnosis of simple CWP. However, he explained that the "mild [CWP]" present in Miner did not contribute to his death in any fashion, and, likewise, it did not cause any respiratory impairment or pulmonary disability in Miner. (DX 23).
10. **Dr. Richard Naeye**, who is Board-certified in the areas of anatomic and clinical pathology, submitted a medical opinion dated October 25, 1999, based on a review of five glass slides containing samples of Miner's lung tissue. Dr. Naeye determined that two slides revealed "[t]he minimal findings required to make the diagnosis of very mild, simple [CWP]," but explained that "[the] findings are so minimal that there is no possibility that this CWP caused any impairments in lung function or any degree of disability," or Miner's death. Dr. Naeye also stated that Miner's centrilobular emphysema was mild at best. (DX 25).
11. **Dr. P. Raphael Caffrey**, who is Board-certified in the areas of anatomical and clinical pathology, submitted a report dated November 4, 1999, in which he stated that Miner suffered from "a very minimal degree of simple [CWP]" due to the "minimal to mild amount of anthracotic pigment" he observed in the subpleural region. Dr. Caffrey's opinion is based upon a review of various medical data, including the glass slides containing samples of Miner's lung tissue. Dr. Caffrey stressed that "only a minimal to mild amount of anthracotic pigment" is present in Miner, and that the simple CWP he detected "could not have disabled [Miner] or caused him any respiratory impairment [or pulmonary disability] prior to his death." Dr. Caffrey diagnosed Miner with mild centrilobular emphysema after reviewing the slides, and found no evidence of complicated pneumoconiosis. (DX 28).
12. A November 29, 1999 medical report from **Dr. Stephen T. Bush** was also submitted. Dr. Bush, who is Board-certified in the area of pathology, with a subspecialty in the area of anatomic and clinical pathology, and "special

competence” in the field of medical microbiology, determined that Miner suffered from “a very mild degree of simple [CWP],” a diagnosis that is based, in part, on a microscopic evaluation of Miner’s lung tissue samples. Dr. Bush stated that none of the twenty-seven x-ray interpretations he reviewed showed any evidence of pneumoconiosis, but that after reviewing the lung tissue samples mentioned above, he concluded that Miner suffered from a “very mild degree of [CWP].” Dr. Bush notes that black dust pigment appeared in Miner’s lungs, and that Miner’s lung tissue also exhibited signs of “minimal” focal dust emphysema. Dr. Bush next stated that Miner did not suffer any pulmonary impairment or respiratory impairment or disability, and that the mild simple CWP could not have caused or aggravated any respiratory ailment or disability. Finally, while Miner was totally disabled, it was due to his colon cancer, diabetes, and right leg amputation; Miner’s “very mild” simple CWP did not contribute to his disability or death. (DX 33).

13. **Dr. William Massello** offered a medical opinion dated February 7, 2000 based solely upon a review of Dr. Oxley’s autopsy report. Dr. Massello concluded that Miner’s CWP played no role in Miner’s death, although he also stated (contrary to the microscopic diagnosis) that the autopsy report “does not indicate the presence of [CWP].” (DX 34).
14. **Dr. James R. Castle** also offered a medical opinion, dated February 10, 2000, in which he agreed that Miner suffered from simple CWP, but that the disease had no effect on Miner’s death or any disease he suffered from when alive. Dr. Castle is Board-certified in internal medicine with a subspecialty in pulmonary diseases as well as a B-reader. Dr. Castle had the opportunity to review a large amount of Miner’s medical data and concluded that Miner had “pathologic evidence of simple [CWP].” In Dr. Castle’s opinion, Miner did not show any evidence of suffering from “any obstruction, restriction, or diffusion abnormality,” and, further, the “very mild” reduction in FVC and hypoxemia Miner had was related to his obesity, as obesity is a risk factor associated with pulmonary disease. Dr. Castle agreed with several other pathologists who reviewed the autopsy materials that the CWP present in Miner did not contribute to any physiologic abnormality. Dr. Castle’s opinion is that Miner did suffer from CWP, but to such a minimal degree that it had no effect on either his “very mild” respiratory impairment, his disability, or his death, and that from a respiratory standpoint, Miner was not disabled. Dr. Castle concluded by stating that Miner “was not permanently and totally disabled as a result of any process arising from his coal mining employment.” (DX 37).
15. **Dr. Samuel V. Spagnolo**, a Board-certified physician in the area of internal medicine with a subspecialty in pulmonary diseases, offered a medical opinion dated February 11, 2000. Dr. Spagnolo concluded that Miner suffered from CWP, but he did not have a “pulmonary/respiratory impairment attributable to

pneumoconiosis. . . .” After reviewing the medical data provided to him, Dr. Spagnolo concluded that Miner’s x-rays and lung tissue samples exhibited “minimal sub-radiographic evidence of [CWP],” but that “[w]ithout a doubt, the extent of the pneumoconiosis was too limited to have resulted in any impairment of lung function.” Dr Spagnolo explained that any abnormal arterial blood gas and pulmonary function test results are related to his obesity. Dr. Spagnolo further stated that none of Miner’s complaints or physical problems were related to coal dust exposure, and that coal dust exposure and pneumoconiosis did not contribute to or cause any disease Miner had, or his death. Finally, Dr. Spagnolo concluded that prior to developing cancer and having his leg amputated, Miner could have returned to his last coal mine job. (DX 36).

16. A February 23, 2000 medical report from **Dr. Thomas M. Jarboe**, who is Board-certified in the area of internal medicine, is also included in the record. Dr. Jarboe offered an opinion that Miner suffered from CWP, and that he suffered from a very mild pulmonary/respiratory impairment “in the form of a mild restrictive defect.” Dr. Jarboe based this latter opinion primarily on the pulmonary function test results, and acknowledged that Miner’s results have been “somewhat” inconsistent. However, Dr. Jarboe explained that while the results do not conclusively establish whether or not a “true restriction is present,” the results do support a conclusion that Miner suffered from “a mild restrictive effect,” although he does not feel that coal dust exposure caused this effect. Dr. Jarboe stated that the degree of CWP present in Miner was very minimal and too insufficient to have contributed to or caused the mild restrictive defect he concluded Miner suffered from, and explained that in individuals who suffer from coal dust-related impairments, both their FVC and FEV₁ values decrease. Miner’s results, by contrast, did not show a reduction in his FEV₁ value, indicating to Dr. Jarboe that his impairment was not related to coal dust exposure. Dr. Jarboe could not definitively state what caused Miner’s mildly reduced FVC, but mentioned his obesity and congestive heart failure as possible factors. Dr. Jarboe also opined that, from a purely respiratory and pulmonary standpoint, Miner retained “functional respiratory capacity” to return to his last coal mining job, although his other medical problems, namely his cancer, diabetes, high blood pressure, and obesity, prevented him from doing so. In conclusion, Dr. Jarboe stated that coal dust exposure played no role in any disability Miner experienced, or any part in his death. (DX 35).
17. **Dr. Castle** supplemented his medical opinion through deposition testimony taken on April 25, 2000, in which he reasserted his opinions summarized above. Dr. Castle restated that Miner’s pathological evidence supports a diagnosis of “very minimal” simple CWP, and that the physiologic studies showed evidence of a very mild restriction, which Dr. Castle attributes to Miner’s obesity; there was no evidence of any obstructive problems. To Dr. Castle, the blood gas and pulmonary function test results did not reveal any evidence of a significant breathing

impairment. Finally, Dr. Castle restated his opinion that Miner's simple CWP did not impact his death in any way. (DX 40).

18. **Dr. Naeye** supplemented his medical report through deposition testimony taken on May 2, 2000. At the deposition, Dr. Naeye explained that evidence of black pigment in an individual's lung is not evidence of lung dysfunction *per se*, and that the rest of the lung still needs to be examined for evidence of other disease. Dr. Naeye testified that Miner's blood gas and pulmonary function test results did not reveal evidence of any significant breathing impairments, or any abnormalities related to intrinsic lung disease, and attributed the slight decrease in FVC value to the physical strain Miner's obesity placed on his respiratory system. Dr. Naeye then explained that he offered a diagnosis of simple CWP because there were small deposits of black pigment in Miner's lung tissue, not exceeding one millimeter in size, and two of these deposits had associated fibrosis, thereby satisfying the definition. However, the amount of coal-dust-associated fibrosis he detected only justified a diagnosis of "very mild simple CWP," and "most people reviewing these findings would say that CWP was absent." Dr. Naeye continued by testifying that the amount of simple CWP present in Miner was insufficient to affect his lung function in any way and would not have resulted in exertional dyspnea, which was caused by the Miner's obesity. Finally, Dr. Naeye noted that Miner did exhibit some signs of suffering from mild centrilobular emphysema, and that coal dust exposure would in general only have a small effect on the development of the disease. He also indicated that coal dust had not been found to be related to lung cancer. (DX 41).

Death Certificate. A certified death certificate signed by Dr. Ford verifies that Miner was born on October 24, 1924, and died on July 12, 1997. Dr. Ford listed "gunshot wound to head" as the immediate cause of death, and "suicide" and "depression" as underlying causes of death. Additionally, "colon cancer with metastasis" is listed as a "significant condition contributing to [Miner's] death but not resulting in the underlying [primary or secondary] cause[s]." (DX 5).

Other Medical Evidence: CT Scans. The record also contains the following three interpretations of CT scans.

Exhibit Number	Date of CT Scan	Physician	Interpretation
DX 7	2/5/97	Dr. Gopalan	"There are slightly prominent interstitial markings seen in the right middle lobe. No focal parenchymal mass lesion is noted." Small, nonspecific lymph nodes in pretracheal space. Calcific granulomas in subcarinal and right hilar regions. No focal mass lesion or pleural effusion.

DX 24	2/5/97	Dr. Wheeler	No pneumoconiosis. Minimal arteriosclerosis in left coronary and aorta. "Small calcified granulomata in lower right hilar nodes and possible 2 cm. calcified granuloma in right superior mediastinum from healed TB or histoplasmosis." "Few small pretracheal and left upper anterior mediastinal nodes from healed inflammatory disease."
DX 24	2/5/97	Dr. Scott	No evidence of silicosis or CWP. "Few small calcified granulomata right hilum. Arteriosclerosis thoracic aorta. Small area of increased attenuation anterior right mid lung probably corresponds to thickened minor fissure."

Discussion and Analysis

Benefits are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners who died from pneumoconiosis. *See* 20 C.F.R. § 725.1(a) (1998). Pneumoconiosis, commonly known as "black lung disease," is a chronic disease of the lungs and its sequelae (including respiratory and pulmonary impairments) resulting from coal mine employment. *See id.* § 725.101(a)(20). *See generally* 20 C.F.R. Parts 718 and 727.

The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

As the instant case arises out of a claim initially filed in March 1976, the regulations appearing at 20 C.F.R. Part 727 and the interim presumption appearing therein are applicable. 20 C.F.R. § 727.103 (1998); *see also* 20 C.F.R. §§ 727.101, 727.102(b) (1998). Pursuant to section 727.203(a)(1)-(5), relating to the interim presumption, a miner who engaged in coal mine employment for at least ten years will be presumed to be totally disabled due to pneumoconiosis and his death will be presumed to have arisen from pneumoconiosis, based upon: (1) a chest x-ray, biopsy, or autopsy establishing pneumoconiosis; (2) ventilatory studies establishing a chronic respiratory or pulmonary disease; (3) blood gas studies demonstrating an impairment in the transfer of oxygen; (4) well-reasoned, well-documented medical opinions or other medical evidence establishing a totally disabling pulmonary or respiratory impairment; or (5) lay evidence, if the miner is deceased and there is no medical evidence. Under 20 C.F.R. § 727.203(b)(1)-(4), the opposing party may rebut the presumption by showing that: (1) the miner is doing his usual coal mine or comparable gainful work; (2) he is capable of doing such work; (3) his disability is not related to coal mine employment; or (4) he does not have pneumoconiosis.

As discussed above, the instant claim is a claim for modification, as Miner submitted a request for modification within one year of the time that Judge Neusner's October 11, 1989 denial became final. The standards for granting a request for modification of a previous denial of

benefits, as Claimant seeks here with respect to the Miner's claim, are set forth in the regulations at 20 C.F.R. § 725.310(a) (1999).²¹ That regulation states, in pertinent part:

Upon . . . the request of any party on grounds of a change in conditions or because of a mistake in a determination of fact, the deputy commissioner [district director] may, . . . at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

Thus, in a case involving a modification request, the threshold issue is whether the claimant has established a change in conditions or mistake in a determination of fact, as provided in 20 C.F.R. § 725.310. To determine whether there has been a change in conditions, the ALJ must "perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision." *Napier v. Director, OWCP*, 17 B.L.R. 1-111, 1-113 (BRB 1993); *Natolini v. Director, OWCP*, 17 B.L.R. 1-82, 1-84 (BRB 1993). An ALJ may also grant modification premised upon a mistake in determination of fact based upon an allegation that the ultimate fact was mistakenly decided; "[t]here is no need for a smoking-gun factual error, changed conditions, or startling new evidence." *Jessee v. Director, OWCP*, 5 F.3d 723, 725 (4th Cir. 1993). The *Jessee* court continued by explaining that, in looking for a mistake in fact, "[n]o new evidence is required. A claims examiner may 'correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted.'" *Id.* at 724 (quoting *O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971) (per curiam) (decided under Longshore and Harbor Workers' Compensation Act)).

If a basis for modification is found, the claim must be considered on the merits, based upon all the evidence of record. *See Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156, 1-158 (BRB 1990), *modified on recon.*, 16 B.L.R. 1-71, 73 (BRB 1992).

Judge Neusner denied Miner's claim on the basis that he did not establish the existence of the disease based upon the x-ray evidence²² so as to invoke the interim presumption under subsection (a)(1), and, further, that the medical opinion evidence failed to show that Miner suffered from a respiratory or pulmonary impairment of sufficient degree to preclude Miner from performing his previous coal mine employment so as to invoke the interim presumption under subsection (a)(2). (DX 29-41, at 3-6). After determining that the interim presumption was not available to Miner, Judge Neusner analyzed his claim under Parts 410 and 718 and found that entitlement was not warranted under these parts for the same reasons for denial under part 727. (*Id.* at 6). Finally, pursuant to BRB's "specific mandate," Judge Neusner analyzed the claim

²¹ The 1999 version of section 725.310 is applicable to this claim. 20 C.F.R. §725.2(c) (2001).

²² Although subsection 727.203(a)(1) allows consideration of biopsy and autopsy evidence, in addition to x-ray evidence, there was no pathological evidence to consider at that time.

under 20 C.F.R. § 410.490 and found that Miner could not prove entitlement under this section either. (*Id.* at 6-7). Thus, if Claimant can successfully show that a change in conditions on any of these elements exists, or that a mistake in fact was made regarding one of these elements, the claim will be considered on its merits.

Miner's Claim: Modification

Change in Conditions. A change in condition has been established, as the autopsy evidence establishes the presence of pneumoconiosis and, thus, invocation of the interim presumption under section 727.203(a)(1) is appropriate. Preliminarily, I note that the record contains no biopsy evidence.

After reviewing the x-ray interpretations submitted in connection with this claim, I find that they are insufficient to establish the presence of the disease. The record contains fifty-one x-ray interpretations, with an overwhelming majority being read by the most qualified doctors as negative for pneumoconiosis. In fact, none of the x-rays taken on or after May 8, 1986 were interpreted by any doctor, irrespective of credentials, as positive for pneumoconiosis, and the record contains only seven interpretations that support a finding of the disease, with only one (DX 29-14) being of acceptable film quality as well as being offered by a BCR, B-Reader (Dr. Navani). The remaining positive interpretations are either outweighed by the negative interpretations of other x-rays offered by more qualified physicians (specifically, DX 16, 29-11, 29-19, 29-21, 29-32, and 29-33), or are entitled to lesser weight due to poor film quality (DX 29-33).²³ Additionally, Dr. Navani's positive interpretation of Miner's February 6, 1972 x-ray is undermined by his own May 8, 1986 interpretation in which he finds no evidence of CWP. (***Compare*** DX 29-11 ***with*** 29-26). In sum, the x-ray evidence submitted in connection with this claim fails to establish that Miner suffered from pneumoconiosis.

However, after the autopsy evidence submitted in support of this claim is evaluated, it is clear that Miner suffered from pneumoconiosis. Dr. Oxley, who performed the August 1997 autopsy, offered a diagnosis of simple CWP after examining samples of Miner's lung tissue that he extracted at the autopsy. (DX 6). Similarly, all of the highly qualified pathologists who subsequently examined the samples universally agree with Dr. Oxley and his conclusion that Miner suffered from simple CWP. (DX 23, 25, 28, 33). Autopsy evidence has been recognized by the BRB and the U.S. Court of Appeals for the Fourth Circuit, which has appellate jurisdiction over this claim, as the most reliable evidence of the existence of pneumoconiosis, provided that no other reason exists to afford such evidence less weight. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 209 (4th Cir. 2000) (citing *Griffith v. Director, OWCP*, 49 F.3d 184, 187 (6th Cir. 1995)); *Urgolites v. Bethenergy Mines, Inc.*, 17 B.L.R. 1-20, 1-22 n.3 (BRB 1992); *Terlip v. Director, OWCP*, 8 B.L.R. 1-363, 1-364 to 1-365 (BRB 1985); *Fetterman v. Director, OWCP*, 7 B.L.R. 1-688, 1-691 (BRB 1985); *Kinnick v. Nat'l Mines Corp.*, 2 B.L.R. 1- 221, 1-224 (BRB

²³ Other x-ray interpretations that are entitled to less weight due to poor film quality are located in DX 7, 17, 24, 29-14, and 29-21, all of which were interpreted as negative for pneumoconiosis.

1979). Here, the autopsy physician as well as all of the pathologists who examined the lung tissue samples agree that Miner suffered from simple CWP. Moreover, while Dr. Oxley's credentials are not in the record, the remaining reviewing pathologists possess impeccable credentials. Thus, the autopsy evidence supports Claimant's contention that Miner suffered from the disease.

Subsection (a)(1) does not reference CT scan evidence. However, whether such evidence is considered will not change the outcome as findings on CT scans were similar to those on x-rays and were negative for coal worker's pneumoconiosis.

After the x-ray interpretations and all of the autopsy evidence is weighed together, I find that the record establishes a change in conditions, as Claimant has proved through the newly submitted medical evidence that Miner had pneumoconiosis, an element previously adjudicated against Miner.²⁴ While the few positive x-ray interpretations supporting a determination that Miner suffered from pneumoconiosis are outweighed by the negative x-ray interpretations, the autopsy evidence clearly supports a finding that Miner suffered from simple CWP. *See Terlip v. Director, OWCP, supra* (requiring all evidence under (a)(1) to be weighed together); *see also Mullins Coal Co., supra*. I find that the pathologist's opinions on this issue are entitled to greater weight, consistent with the position of the BRB and Fourth Circuit that autopsy evidence provides the most probative evidence on this particular issue.²⁵ As such, Claimant has successfully proven by a preponderance of the evidence that Miner suffered from the disease, an element previously decided against Miner, and evaluation of the merits of the claim is proper.

Miner's Claim: Merits of the Claim Under Part 727

Invocation of the Interim Presumption. Claimant has successfully proven by a preponderance of the evidence that it is proper to invoke the interim presumption contained in 20 C.F.R. § 727.203. As discussed above, to invoke the presumption, a claimant must establish both that a miner engaged in coal mine employment for at least ten years, and one of the five "medical requirements" contained in section 727.203(a). *Wise v. Peabody Coal Co.*, 3 B.L.R. 1-119 (1981).

Invocation of the interim presumption is appropriate, as the Miner worked in coal mining for thirty-two years, and the medical evidence, specifically the autopsy evidence, establishes that

²⁴ The autopsy evidence also establishes that a mistake in fact was made on this issue, although clearly the autopsy evidence was not available when Judge Neusner heard Miner's claim. Thus, while separate analysis is unnecessary by virtue of my determination that a change in conditions exists, I note that the evidence would also support a finding of a mistake in fact was made on the same element of denial, and analysis of the merits of the claim would be warranted as well.

²⁵ It is implicit in every single claim for black lung benefits that, in evaluating the medical evidence submitted, the finder of fact focus on the quality of the evidence presented, not mere quantity. *See, e.g., Mullins Coal Co. of Va. v. Director, OWCP*, 484 U.S. 135, 149 n.23 (1988).

Miner suffered from pneumoconiosis for the reasons discussed above in the context of establishing that a change in conditions exists. Thus, Claimant has shown by a preponderance of the x-ray and autopsy evidence that Miner suffered from pneumoconiosis, and invocation under (a)(1) is appropriate. As such, it is unnecessary to consider the applicability of the other bases for invocation of the interim presumption and I will now consider whether the Director has established a basis for rebuttal under 20 C.F.R. § 727.203(b)(1)-(4).

Rebuttal of the Interim Presumption. Once a claimant has submitted evidence sufficient to invoke the interim presumption, the party opposing entitlement has the burden of establishing rebuttal by a preponderance of the evidence. *See Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *see also Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 939 (4th Cir. 1980); *Laird v. Alabama By-Products Corp.*, 6 B.L.R. 1-1146, 1-1149 (BRB 1984). As mentioned above, under 20 C.F.R. § 727.203(b)(1)-(4), the opposing party may rebut the presumption by showing any of the following: (1) the miner is doing his usual coal mine work or comparable and gainful work; (2) he is capable of doing his usual coal mine work or comparable and gainful work; (3) his disability (or death) did not arise, in whole or in part, from coal mine employment; or (4) he does or did not have pneumoconiosis.

Preliminarily, rebuttal cannot be established under subsections (b)(1), (b)(2), or (b)(4). Subsection (b)(1) is applicable when “[t]he evidence establishes that the individual is, in fact, doing his usual coal mine work or comparable and gainful work. . . .” It is undisputed that Miner died in 1997 and, thus, any rebuttal premised on a theory that Miner is currently working must fail. Subsection (b)(2) applies when, “[i]n light of all relevant evidence, it is established that the individual is able to do his usual coal mine work or comparable and gainful work. . . .” While Miner’s death does not automatically preclude subsection (b)(2) rebuttal, *Blair v. R & E Coal Co.*, 16 B.L.R. 1-113, 1-117 (BRB 1992), the Fourth Circuit’s “whole-man” standard could not possibly be met due to the complications Miner experienced during his lifetime due to his colon cancer, diabetes, hypertension, and right leg amputation. (*See, e.g.*, DX 33, 36, 35; *see also* DX 29-19, 29-32, 29-46 (older medical opinions stating that Miner is totally disabled)). Thus, rebuttal under (b)(2) is unavailable. *See Grigg v. Director, OWCP*, 28 F.3d 416 (4th Cir. 1994); *Sykes v. Director, OWCP*, 812 F.2d 890 (4th Cir. 1987). Further, rebuttal under subsection (b)(4) is precluded when the presumption is invoked under section 727.203(a)(1).²⁶ *Curry v. Beatrice Pocahontas Coal Co.*, 18 B.L.R. 1-59 (BRB 1994) (*en banc*) (J. Brown and McGranery concurring and dissenting), *rev’d on other grounds, Curry v. Beatrice Pocahontas Coal Co.*, 67 F.3d 517 (4th Cir. 1995); *Buckley v. Director, OWCP*, 11 B.L.R. 1-37 (BRB 1988) (citing *Mullins Coal Co. of Va. v. Director, OWCP*, 484 U.S. 135, 150 n.26 (1988)). As a

²⁶ While the Fourth Circuit has not formally adopted this position, several decisions, all favorably discussing footnote twenty-six of *Mullins Coal Co. of Va. v. Director, OWCP*, 484 U.S. 135 (1988), suggest that the Fourth Circuit concurs with the BRB’s approach. *See, e.g., Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 804 (4th Cir. 1998). *See also Curry v. Beatrice Pocahontas Coal Co.*, 67 F.3d 517, 522-24 (4th Cir. 1995).

result, this leaves subsection (b)(3) as the Director's only avenue to rebut the interim presumption.

To establish rebuttal under subsection (b)(3), the party opposing entitlement must show that "the total disability or death of the miner did not arise in whole or in part out of coal mine employment." 20 C.F.R. § 727.203(b)(3) (1998). To succeed in rebutting the presumption under this subsection, the party opposing entitlement must "disprove the causal relationship between coal mine employment and total disability once the claimant establishes the existence of a qualifying medical condition." *Bethlehem Mines Corp. v. Massey*, 736 F.2d 120, 124 (4th Cir.1984). Further, in cases where the miner is disabled by "the combined effects of several diseases," the evidence "must establish that the miner's primary condition . . . was not aggravated to the point of total disability by prolonged exposure to coal dust." *Id.* As the Fourth Circuit noted in *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 804 (4th Cir. 1998): "Rebutting the presumption under this provision is not easy. . . . Because of the 'in part' language, 'the [party opposing benefits] must rule out the causal connection between the miner's total disability and his coal mine employment[.]'" *Id.* (quoting *Massey*, 736 F.2d at 123) (emphasis and internal citations omitted); *see also Grigg v. Director, OWCP*, 28 F.3d 416, 418 (4th Cir. 1994) (recognizing difficulty in rebutting the interim presumption under subsection (b)(3)); *Thorn v. Itmann Coal Co.*, 3 F.3d 713, 718 (4th Cir. 1993) (same).

In order to satisfy the "rule out" standard, the party opposing entitlement must offer proof taking one of two forms: (1) "positive evidence demonstrat[ing] that the miner suffers from no respiratory or pulmonary impairment of any kind," or, if such an impairment does exist, (2) "evidence explain[ing] all of any impairment present and attribut[ing] it solely to sources other than coal mine employment." *Lane Hollow*, 137 F.3d at 804-05 (citations omitted); *see also Consolidation Coal Co. v. Borda*, 171 F.3d 175, 184-85 (4th Cir. 1999). Thus, the party opposing entitlement may show either that the miner had no respiratory or pulmonary impairment, or that "any impairment [present] was not caused by coal mine employment." *Borda*, 171 F.3d at 184. Finally, in evaluating the evidence, "[a] non-examining physician's opinion on matters not addressed by examining physicians is insufficient as a matter of law to rebut an interim presumption under 20 C.F.R. § 727.203." *Massey*, 736 F.2d at 125, *quoted in Malcomb v. Island Creek Coal Co.*, 15 F.3d 364, 370 (4th Cir. 1994).²⁷ In sum, the focus of rebuttal under subsection (b)(3) is not whether Miner is totally disabled, as that is presumed, but rather whether the Director can disprove any and all connection between Miner's total disability and his coal mine work.

Although (b)(3) presents a very rigorous standard, it is one that the Director has met in this instance, as the medical opinions establish by a preponderance that Miner's simple CWP

²⁷ I note that Miner's obesity (which most of the reviewing physicians found to be the cause of the Miner's respiratory abnormalities) was acknowledged as a possible cause of Miner's dyspnea on exertion, but rejected as a cause of dyspnea at rest or of his "diminished diffusing capacity" by at least one examining physician (Dr. Robinette), thereby satisfying *Massey*. (DX 29-32).

played no role in causing or aggravating his total disability. Preliminarily, Dr. Massello, who only reviewed the autopsy report, did not diagnose Miner with CWP (DX 34), and because of this erroneous finding, his opinion is entitled to very little weight on this issue. *See Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1192-93 (4th Cir. 1995) (citing *Grigg v. Director, OWCP*, 28 F.3d 416, 419 (4th Cir. 1994)). However, the remaining newer medical opinions are unanimous in diagnosing Miner with simple CWP and shall not be discredited on this particular basis.

Lane Hollow identified two general categories of evidence that must be considered when addressing (b)(3) rebuttal. Dr. Bush and Dr. Spagnolo both offer opinions stating that Miner did not suffer from any pulmonary or respiratory impairment and, thus, offer evidence falling within the first type of proof. (DX 33, 36). However, I find that these physician's opinions are entitled to less weight, as a majority of the other medical opinions diagnose Miner with some type of respiratory impairment.²⁸ ((DX 23, 25, 28, 35, 37, 41). While *Lane Hollow* and *Borda* do not hold that the two types of "proof" are mutually exclusive, it would be inconsistent to afford opinions that find no respiratory impairment the same amount of weight as the opinions that do identify some form of impairment, as one set of opinions would be based upon an erroneous finding. *Cf. Grigg, supra*. Thus, the opinions from Drs. Bush and Spagnolo will not be afforded much weight on this particular issue, although these opinions have been considered.

The *Lane Hollow* and *Borda* courts, though, recognized a second category of proof: evidence that acknowledges that the miner suffers from some type of respiratory/pulmonary impairment, but that successfully establishes that a source other than pneumoconiosis caused the Miner's disability. It is within this second category that many of the medical opinions fall into, as several physicians conclude that Miner suffers from various respiratory/pulmonary impairments, in particular hypoxemia, dyspnea, and a reduced FVC and/or a restrictive ventilatory defect.

The majority of the physicians offering post-1997 medical opinions in connection with this claim not only emphatically disavow any causal connection between Miner's total disability and his simple CWP, but go further and establish that Miner's pneumoconiosis had no effect whatsoever on his slight respiratory impairment, which did not contribute to Miner's total disability in the first place.²⁹

First, Dr. Castle, a highly qualified specialist in pulmonary disorders, stated that "[Miner] had no significant respiratory impairment whatsoever from any cause. The very mild reduction in [FVC] was due to obesity and did not cause him any disability. . . . He was not permanently and

²⁸ Many of the older medical opinions offered by physicians who personally examined Miner also observed that Miner suffered from some type of respiratory impairment. (DX 29-12, 29-19, 29-23, 29-32, 29-46).

²⁹ While the physicians offering these post-mortem medical opinions did not personally examine Miner during his lifetime, their thorough reviews of the record and well-reasoned explanations are relevant evidence of rebuttal under Part 727. *Szafraniec v. Director, OWCP*, 7 B.L.R. 1-397 (BRB 1984).

totally disabled as a result of any process arising from his coal mining employment.” (DX 37). Further, Dr. Castle attributed Miner’s total disability to his colon cancer, cited Miner’s obesity as the cause of his “very mild degree of hypoxemia at rest,” and stated that the simple CWP in Miner was “so minimal” that it “cause[d] him no physiologic abnormality.” (*Id.*; *see also* DX 40, at 20).

Dr. Jarboe, who also reviewed a significant amount of Miner’s medical data, offered an opinion of less conviction in ruling out any role that Miner’s simple CWP played in aggravating or causing any impairments Miner exhibited, as well as his disability. Dr. Jarboe stated that it was his opinion that Miner “may have had a very mild impairment in the form of a mild restrictive defect” based upon a review of Miner’s pulmonary function values, but that this defect “has not been caused by coal dust inhalation or CWP” because Miner’s physiological test results did not produce a reduced FEV₁ value, which typically occurs with individuals suffering from lung disorders attributable to coal dust exposure. (DX 35). Dr. Jarboe further stated that “[w]ithin reasonable medical probability and/or certainty, it is my opinion that [Miner’s] coal dust exposure did not play any role in any disability he may have had prior to [his] death.” (*Id.*) Dr. Jarboe suggested obesity and congestive heart failure as possible etiologic factors, but he did not reach a definite conclusion as to the cause of the nondisabling respiratory impairment that he found.

Dr. Naeye, who had an opportunity to review all of the medical evidence and personally review the lung tissue samples, definitively stated in his medical opinion that Miner’s simple CWP is “so minimal that there is no possibility that this CWP caused any impairments in lung function or any degree of disability.” (DX 25). Dr. Naeye further explained at his deposition that all of Miner’s physiological test results are normal and that Miner’s pulmonary function studies did not reveal any abnormalities related to intrinsic lung disease. (DX 41, at 16-17). While Dr. Naeye did state that the same test results showed a slight decrease in FVC value, he also attributed this to Miner’s obesity. (DX 41, at 16). When asked if Miner’s CWP had any effect on Miner’s lung function, Dr. Naeye replied, “No. None whatsoever.” (*Id.* at 18). Dr. Naeye’s deposition concluded with the following exchange:

Q. Did the [CWP] which you found in the lungs at the time of the autopsy play any role in causing impairment during [Miner’s] lifetime?

A. **No. It had no effect whatsoever on lung function. It didn’t cause any impairments or any disability whatsoever.**

Q. [Claimant] noted on the application for benefits that her husband experienced breathing problems in his last several years of his life and especially became short of breath upon climbing stairs. Was that because of a lung problem or some other disease entity?

A. Well, he was obese. And let me tell you, being obese and old age causes a lot of problems in terms of exercise and disability – not disability, but shortness of breath. And so I would say that this exertional dyspnea in his late years was related to – primarily related to his obesity.

There certainly wasn't enough lesion of any sort in his lungs to have caused any exertional dyspnea.

((*Id.* at 21) (emphasis added)).

Dr. Bush also offered an opinion unequivocally disassociating Miner's simple CWP from any disability he suffered from. Dr. Bush, who did not find any evidence that Miner suffered from a respiratory or pulmonary impairment, nonetheless offered a hypothetical opinion that the "very mild degree of simple [CWP] could not have caused or contributed to respiratory impairment." (DX 33). Dr. Bush attributed Miner's total disability, solely to his widespread cancer and right leg amputation. (*Id.*). However, as Dr. Bush found no respiratory impairment whatsoever, contrary to the weight of the evidence, his opinion concerning the possible contribution by the Miner's simple CWP to his disability is not compelling.

The remaining post-1997 opinions appear to fall short of the Fourth Circuit's "rule-out" standard for various reasons. Dr. Hansbarger "believe[s] that there was no respiratory impairment or pulmonary disability present" in Miner due to his the CWP because of "the mild nature of the pneumoconiosis" (DX 23) (offering a diagnosis of CWP after finding evidence of "pulmonary anthracosilicosis of a degree just sufficient" to warrant such a diagnosis). Dr. Hansbarger, though, fails to directly address the etiology of Miner's total disability, and his opinion is somewhat equivocal. Dr. Caffrey stated that Miner's "very minimal" simple CWP "certainly would not have caused any pulmonary disability." (DX 28). Again, this is somewhat of an equivocal opinion. Dr. Spagnolo, who, like Drs. Naeye and Jarboe, reviewed Miner's entire medical history, but, like Drs. Bush did not find any evidence of respiratory or pulmonary impairment, stated that "the findings of [CWP] were so minimal that there was no possibility that CWP could have caused any impairment of lung function" and "[i]t is also my opinion that none of [Miner's] symptoms, complaints, or medical conditions were related to his coal dust exposure or coal mine employment." (DX 36). However, while Dr. Spagnolo states that Miner's lung function was totally unaffected by his simple CWP, he fails to address the issue of what caused the Miner's total disability. Still, despite the deficiencies noted in these opinions, none of these opinions contradict or undermine the conclusions of the other post-1997 opinions discussed above.

Further, none of the older medical evidence supports a contrary finding due to their equivocal nature. When coupled with the fact that all of the older opinions were based upon an incomplete picture of Miner's health, as they were all written prior to Miner contracting cancer

and prior to his right leg amputation, I have determined that they are significantly outweighed by the newer medical opinions.

Preliminarily, none of the pulmonary function and arterial blood gas tests produced results that were qualifying under the regulations, and while some of these opinions report complaints of coughing, shortness of breath, and wheezing, none of the older medical opinions contain a definitive conclusion that Miner was totally disabled due in part to his pneumoconiosis or any other disease affecting his pulmonary or respiratory function.

Dr. Kanwal offers the closest opinion, stating in November 1990 that Miner was “totally and permanently disabled,” and commenting that he “feel[s] [that Miner’s] respiratory symptoms and condition is related to coal mine exposure.” (DX 29-46). While Dr. Kanwal’s opinion is entitled to more deference due to his status as treating physician, the force of his opinion is weakened by the equivocal language he uses. (*Id.*). Further, Dr. Kanwal’s respiratory diagnosis was limited to “Chronic lung disease with chronic bronchitis,” although he also noted “Coal dust exposure,” and he did not comment upon the possible contribution of his other diagnoses of arteriosclerotic heart disease, congestive heart failure, and diabetes mellitus. (*Id.*).

The opinions of Drs. Smiddy, Robinette, and Paranthaman are as equivocal as Dr. Kanwal’s opinion. In this regard, in September 1982, Dr. Smiddy diagnosed coal worker’s pneumoconiosis (along with congestive heart failure and essential hypertension), found that his respiratory condition would preclude coal mine employment, and concluded that the Miner had “sufficient Pneumoconiosis” to produce the hypoxemia and mild pulmonary function abnormalities found, because he was a nonsmoker and had no other sources for respiratory disease. (DX 29-19). This falls short of being a reasoned medical opinion on the issue of etiology. Likewise, in December 1984, Dr. Robinette diagnosed simple coal worker’s pneumoconiosis, mild restrictive lung disease with evidence of mild resting hypoxemia, diabetes mellitus, and exogenous obesity, and, while finding that he should not return to employment which would require significant dust exposure, he did not actually find the Miner disabled. Although concluding that the pneumoconiosis was “symptomatic,” he recognized that the dyspnea on exertion could have other causes, such as the exogenous obesity, but he did not “feel, however, that this would account for diminished diffusion capacity observed or for the decrease in his resting arterial blood gases.” (DX 29-32)). Again, this falls short of a reasoned medical opinion on etiology due to its equivocal nature. Dr. Paranthaman’s May 1986 opinion, while not finding CWP, found chronic bronchitis that was “probably due to coal dust exposure as he is a non smoker” (in addition to moderate hypertension and insulin dependent diabetes mellitus) and, while noting mild to moderate blood gas abnormalities as well as mild to moderate “functional abnormality,” he did not explain what caused these abnormalities. Dr. Paranthaman determined that all of the Miner’s medical problems would make it difficult for him to do the job of a miner on an eight hour basis, but he did not attempt to quantify the contribution of each. (DX 29-23).

The remaining older opinions, those of Drs. Buchanan and Barton dating from the early 1970's, do not assist the Claimant in any way, as they merely constitute lists of symptoms and diagnoses without a reasoned analysis. (DX 29-9, 29-11).

In sum, when all of the medical opinions, old and new, are considered, the Director has completely ruled out by a preponderance of the evidence any causal nexus between Miner's simple CWP and any disability he may have experienced. *See Billips v. Bishop Coal Co.*, No. 95-1169, 1996 WL 36136 (4th Cir. Jan. 31, 1996) (unpublished) (upholding rebuttal under (b)(3)).³⁰ Thus, the Director has met the Fourth Circuit's rigorous standard and established by a preponderance of the evidence not only that Miner's simple CWP played no role in his total disability, but also that the disease in no way affected the slight, non-disabling respiratory impairment detected in Miner.

As a final matter, although simple CWP, or "clinical pneumoconiosis," has been discussed above, the Director has also ruled out chronic bronchitis, or "legal pneumoconiosis," as a cause of Miner's disability. In this regard, there is no medical evidence establishing that the chronic bronchitis mentioned in Miner's treatment records and diagnosed by some of the examining physicians in 1990 and before gave rise to any disabling respiratory impairment. Moreover, the medical testimony summarized above establishes that such respiratory impairment as Miner had was most probably due to his obesity. Therefore, legal pneumoconiosis may also be ruled out as a cause of Miner's total disability so as to establish (b)(3) rebuttal.

Accordingly, I find that Claimant has established invocation of the interim presumption based upon establishment of pneumoconiosis under subsection (a)(1), but that the Director has successfully rebutted the interim presumption under subsection (b)(3) by showing by a preponderance of the evidence that Miner's simple CWP played no role in Miner's disability.

Alternate Method of Entitlement: Part 718

When eligibility for benefits is not established under 20 C.F.R. § 727.203, a determination of eligibility under the alternate methods available in the Act and implementing regulations must be made. Section 727.203(d) specifically requires an ALJ to analyze a claim that fails under section 727.203 under part 718 as well. The Benefits Review Board has suggested that analysis should be made under part 410 instead. *See Muncy v. Wolfe Creek Collieries Coal Co.*, 3 B.L.R. 1-627 (1981). Analysis under part 410 is, however, unnecessary in light of Supreme Court and BRB precedent stating that successfully establishing rebuttal under 20 C.F.R. § 727.203(b)(3) or (b)(4) precludes entitlement either under the permanent provisions in part 410 or the interim provision in section 410.490. *See Pauley v. Bethenenergy Mines, Inc.* 501 U.S. 680 (1991) ("[I]t

³⁰ Although *Billips* is an unpublished opinion and, thus, not binding precedent, it is analogous, as it involves a miner that was diagnosed with simple CWP, but (b)(3) rebuttal was accomplished through four (of five) medical opinions that "concluded uniformly that [the miner's] total disability . . . was caused [by an alternate source]." *Billips, supra*.

disserves congressional intent to interpret [20 C.F.R. § 410.490] to allow recovery by miners . . . whose total disability did not arise, at least in part, from their coal mine employment”) (finding that (b)(3) and (b)(4) rebuttal provisions are implicitly included within the section 410.490(c) rebuttal provisions); *Pastva v. Youghiogheny & Ohio Coal Co.*, 7 B.L.R. 1-829, 1-833 (BRB 1985) (“A finding, however, that claimant’s disability did not arise out of his coal mine employment precludes entitlement under [part 727] and the permanent criteria of 20 C.F.R. Part 410, Subpart D.”).

To prevail on a claim for black lung benefits under Part 718, a claimant must prove, *inter alia*, that he or she is totally disabled.³¹ 20 C.F.R. § 718.204(a) (1999); *Tolver v. Eastern Associated Coal Co.*, 43 F.3d 109, 112 (4th Cir. 1995). The regulations set forth several ways a claimant can prove this element of entitlement, such as submission of certain types of medical evidence establishing total disability, or by taking advantage of the irrebuttable presumption in section 718.304 for complicated pneumoconiosis.³² See 20 C.F.R. § 718.204(b)(1)-(2) (2001). The Fourth Circuit specifically requires a showing that the miner is totally disabled solely by the result of a respiratory or pulmonary impairment. *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994).

For the reasons discussed above, I find that while Claimant has presented evidence establishing that Miner suffered from pneumoconiosis, Claimant has not successfully shown that Miner was totally disabled solely by a respiratory or pulmonary impairment. I find that the medical evidence establishes that Miner was totally disabled primarily due to his widespread cancer and right leg amputation, that his slight respiratory impairment was attributable to his obesity and was not disabling, and that his minimal simple CWP did not cause any impairment whatsoever. In making this determination, I give the physicians offering opinions after Miner died more weight, as these physicians not only possess superior credentials, but they also offer opinions based upon Miner’s entire medical history, including the significant medical problems he experienced after 1990 (the date of the most recent opinion offered by an examining physician) in reaching their conclusions. As a result, Claimant cannot prove an essential element of entitlement under part 718 and, as such, the claim must fail.

³¹ The constitutionality of several of the recent amendments to the regulations was recently challenged, with many being upheld by the U.S. Court of Appeals for the District of Columbia. *Nat’l Mining Assoc. v. Dep’t of Labor*, 292 F.3d 849 (D.C. Cir. 2002). However, the court did find that 20 C.F.R. § 718.204(a) (the “total disability rule”), as amended, was “impermissibly retroactive” as applied to cases pending at the time the action was filed (which encompasses this claim), and that “the state of the law on this question exactly as it was prior to the regulations promulgation” should be applied to such cases. *Id.* at 864-65. While the Fourth Circuit’s approach on this issue is essentially the same as that codified in the revised section 718.204(a), the 1999 version will be referenced to comport with the D.C. Circuit’s holding. The D.C. Circuit’s ruling is limited to subsection (a) only.

³² The irrebuttable presumption in section 718.304 only relates to complicated pneumoconiosis, involving lesions which would appear as large opacities greater than 1 centimeter in diameter on x-ray. No such finding has been made here.

ORDER

IT IS HEREBY ORDERED that Westmoreland Coal Company is **DISMISSED** as a party to the claim of Faye E. Falin, on behalf of Leslie Falin, for black lung benefits under the Act and

IT IS FURTHER ORDERED that the claim of Faye E. Falin, on behalf of Leslie Falin, for black lung benefits under the Act be, and hereby is, **DENIED**.

A

PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.